



Mitchell E. Daniels, Jr. , Governor
James W. Payne. Director

Indiana Department of child Services Programs and Services Division
302 W. Washington Street, Room E306, MS08
Indianapolis, Indiana 46204-2773

317-232-8116
FAX:317-234-4633

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline:800-800-5556

DEAR APPLICANT: THE STATE PROVIDES **BI-MONTHLY** TRAINING ORIENTATION SESSIONS, TO INFORM THOSE WHO ARE INTERESTED IN OPENING AND OPERATING THE FOLLOWING TYPES OF FACILITIES.
CHILD CARING INSTITUTION; GROUP HOMES; PRIVATE SECURE FACILITIES; LICENSED CHILD PLACING AGENCY

**TRAINING WILL BE HELD AT THE TRAINING CENTER
INDIANA GOVERNMENT CENTER SOUTH
402 WEST WASHINGTON STREET
INDIANAPOLIS, INDIANA 46204**

*Registration is at 9:30 am (EST): for Child Caring , Group Home and Private Secure Facilities training - Rm.14
Training is scheduled from 10:00 am until approx.4:00 pm*

*Registration is at 1:00 pm (EST) for Licensed Child Placing Agency training - Rm. 21
Training is scheduled from 1:00 pm until approx. 4:00 pm*

(Please note: Classes are subject to cancellation due to low attendance)

Training will be held on Wednesdays on the following dates

February 4, 2009; April 1, 2009; June 3, 2009; August 5, 2009; October 7, 2009; December 2, 2009

*Circle the date you wish to attend, and complete the information below. All information must be completed with a valid address and phone number or your registration **will not be accepted**.*

Mail to: **Residential Licensing Unit / or send your email registration to: Gurline.Jones@dcs.state.in.us**
Attention: Gurline Jones
Division of Family & Children
302 W. Washington St.
IGCS Room E-306
Indianapolis, IN 46204

You may also fax the completed registration to: 317-234-4633. (Fax, email, or postmark must be dated 7 working days prior to class date or you will automatically be placed in the next class) For questions, please call 317-232-8116

TYPE OF TRAINING REQUESTED

Please circle the one you are interested in: Child Caring Institution; Group Home; Private Secure Facility;
Licensed Child Placing Agency;

NAME OF FACILITY: _____

ADDRESS: _____ **PHONE :** _____ (must be valid)

CITY: _____ **STATE:** _____ **COUNTY:** _____ **ZIP CODE:** _____

DUE TO LIMITED SPACE, ONLY TWO (2) PERSONS MAY ATTEND

Persons attending: Name _____ *Title* _____

Name _____ *Title* _____

THIS FORM MUST BE RECEIVED 7 WORKING DAYS PRIOR TO THE REQUESTED TRAINING DATE